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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
INPATIENT SERVICES

XIX. Transition from Regional to Statewide Payment Rates

In order to allow for a transition from payment rates based on region (urban or rural) to statewide payment rates, the following changes are effective for admissions occurring on or after April 10, 1998:

1. Hospitals previously assigned to rural or urban peer groups are combined into one statewide peer group.
2. For the statewide peer group, an adjustment to compensate for expected increases in the accuracy of coding for diagnoses and procedures is changed from a 2% reduction to 0%.
3. For the statewide peer group, payment rates for each hospital is determined by the use of the base rate for the statewide peer group or by the hospital's initial rural or urban peer group rate, whichever is greater.

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## XX. Revisions

Due to revisions to the methods and standards for establishing payment rates for inpatient services, the following identifies previous methods and standards which are no longer in effect:

<u>section</u>	<u>page(s)</u>	<u>date no longer effective</u>
I.E - I.G	1-2	on or before October 9, 1997
II.B	2	on or before October 9, 1997
II.D	3 (lines 14-29) only	on or before October 9, 1997
V.A.1	8	on or before October 9, 1997
V.A.2 line 6-line 40	9	on or before October 9, 1997
V.B	10-16	on or before October 9, 1997
V.C	17-24	on or before October 9, 1997
V.E-F	25-28	on or before October 9, 1997
V.G	31 (lines 13-42) only	on or before October 9, 1997
V.G	34 (line 10)-35 (line 23) only	on or before October 9, 1997
V.G	35 (line 36)-42 (line 15) only	on or before October 9, 1997
V.G	42 (line 21)-43 only	on or before October 9, 1997
V.H	46 (lines 26-32) only	on or before October 9, 1997
V.I	48 (lines 18-19) only	on or before October 9, 1997
X	50-52	on or before October 9, 1997

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<u>section</u>	<u>page(s)</u>	<u>date no longer effective</u>
XIV	54-55	on or before October 9, 1997
XVII	56-69	on July 1, 1998
Not applicable	71	page number omitted
XIX	72	on July 1, 1998

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## METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT SERVICES

### Overview

Effective with dates of service on or after July 1, 1998, the Georgia Department of Medical Assistance (DMA) will reimburse qualified providers for inpatient hospital services under the prospective payment system as set forth in this plan.

### I. Data Sources and Preparation of Data for Computation of Prospective Rates

The calculation of prospective rates requires the use of claims data, cost data and supplemental expenditure data. The historical claims data is obtained from a chosen base year, with adjustments for inflation. For rates effective July 1, 1998, inflation rates are based on projections as calculated by DRI, reduced by 1% per year; this inflation rate may be updated periodically. The cost data is derived from a cost report year where the majority of hospitals have audited data. For rates effective on July 1, 1998, audited data was available for hospital fiscal years ending in 1995 for a majority of hospitals. Hospitals without audited data in the chosen year will have data derived from the hospital's most recently audited cost report. The supplemental data is obtained from state supplemental expenditure surveys. The rate components are used in the calculation of the prospective rates as described in Section II of this plan.

### II. Payment for Inpatient Hospital Services

#### A. Payment Formulas

Non-Outlier DRG Payment Per Case = (Hospital-Specific Base Rate x DRG Relative Rate) + Capital Add-on + GME Add-on (if applicable)

Outlier DRG Payment Per Case = (Hospital-Specific Base Rate x DRG Relative Rate) + {[ (Allowable Charges x Hospital-Specific Operating Cost to Charge Ratio) - (Hospital-Specific Base Rate x DRG Relative Rate)] x A Percentage} + Capital Add-on + GME Add-on (if applicable)

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B. Discussion of Payment Components

1. Base Rates

All hospitals are assigned to a peer group in order to develop a base rate that best matches payments to costs for hospitals that provide similar services. The peer group base rate is obtained by calculating the average operating cost standardized for case mix of Inlier DRG cases across all cases in a peer group. If a hospital is assigned to the statewide or pediatric peer group, the peer group base rate becomes the hospital-specific base rate. If a hospital is assigned to the specialty peer group and has a sufficient claim volume, the hospital-specific base rate will be the greater of the peer group base rate or the individual hospital's base rate. If a hospital is assigned to the specialty peer group and does not have a sufficient claim volume, the peer group base rate becomes the hospital-specific base rate. For each case paid within the DRG methodology, the hospital specific base rate will be multiplied by the appropriate DRG relative weight to calculate a payment.

2. Calculation of the Capital Add-on Amount

Hospitals receive a hospital specific add-on based on capital costs from the cost report year, charges from the rate setting base year and supplemental data from the capital expenditure survey.

3. Calculation of the Direct Graduate Medical Education (GME) Add-on Amount

Only hospitals which have GME costs in the cost report year receive the GME add-on amount. The Medicaid portion of GME from the hospital's cost report year is inflated, then divided by the number of cases in the base year to obtain the GME add-on. For rates effective July 1, 1998, inflation rates are based on projections as calculated by DRI, reduced by 1% per year; this inflation rate may be updated periodically.

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4. Marginal Payments for Outliers

If the cost of a case exceeds the outlier threshold established by DMA, the case qualifies as an outlier and receives an additional payment of a percentage of the difference between the operating cost of the case and the operating portion of the non-outlier DRG payment amount (Hospital-Specific Base Rate x DRG Relative Rate). For rates effective on July 1, 1998, the percentage rate applied is 90%; this percentage rate may be updated periodically.

III. Special Payment Provisions

A. -New Facilities

New facilities under the DRG system will receive payments using the same payment formulas as stated in Section II. However, the components of the formulas will be calculated on a statewide average. A new facility will receive a hospital-specific base rate that is equal to the statewide average rate for the appropriate peer group in which the hospital is classified and a capital add-on payment equal to the statewide average add-on payment for the appropriate peer group.

B. Out-of-State Facilities

Out-of-state facilities under the DRG system will receive payments using the same payment formulas as stated in Section II. However, the components of the formulas will be calculated on a statewide average. An out-of-state facility will receive a hospital specific base rate that is equal to the statewide average rate for the appropriate peer group in which the hospital is classified, a capital add-on payment equal to the statewide average add-on payment for the appropriate peer group, and a cost-to-charge ratio that is equal to the Georgia statewide average of the cost-to-charge ratios.

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C. New Medicaid Providers

Prospective payment rates for established facilities which did not submit a hospital-specific Medicare cost report because the facility did not participate in the Medicaid program will be determined in the same manner as a new facility stated in section III.A.

IV. DRG Grouper

On or after October 1, 1999, the grouper used to classify cases into DRG categories will be changed from CHAMPUS Grouper version 15.0 to CHAMPUS Grouper version 16.0. The grouper used to assign claims to DRG categories, as well as the corresponding DRG weights and threshold amounts, may be updated periodically.

## **PART II - CHAPTER 1000 BASIS FOR REIMBURSEMENT**

### **1001.     Reimbursement Methodology**

Distinct methods of reimbursement have been established for inpatient services provided by Georgia hospitals, for outpatient services provided by Georgia hospitals, and for all services provided by non-Georgia hospitals. Descriptions of these reimbursement methods are presented in Subsections 1001.1 through 1001.4, and in Appendix C.

#### **1001.1     Hybrid Diagnosis Related Group (DRG) Prospective Payment System**

Inpatient services are reimbursed based on a hybrid-DRG prospective payment system. The majority of cases are reimbursed using a DRG per case rate based on the CHAMPUS DRG Grouper 15.0. Remaining cases are paid based on a hospital-specific cost-to-charge (CCR) system. Appendix C describes the hybrid-DRG system in greater detail.

#### **1001.2     Reimbursement for New Hospitals**

For the purposes of inpatient hospital reimbursement, a new hospital is defined as a hospital:

- a) established by the initial issuance of a Certificate of Need, Medicare certification, and state license, and
- b) for which historical base year paid claims data did not exist.

A hospital formed as a result of a merger, acquisition, other change of ownership, business combination, etc. is not a new hospital. Each hospital of this type will maintain the DRG-hybrid system reimbursement components it would otherwise be assigned. When rates are adjusted after the transaction, the appropriate base period information will be used in determining the hospital's rebased reimbursement components.

Reimbursement for inpatient services provided by new hospitals will vary based on when the hospital began operation.

1001.2A Hospitals Reimbursed Under the Hybrid-DRG System with Rate Components that are Not Hospital-Specific

- a) A new hospital is subject to the Hybrid-DRG Prospective Payment System.
- b) Within the DRG portion of the hybrid reimbursement system:
  - 1. The DRG base rate will be the peer group base rate prior to any hospital-specific stop loss adjustment.
  - 2. The per case capital add-on will be based on the peer group average per case capital add-on amount.
  - 3. The per case graduate medical education add-on (if applicable) will be based on the peer group average per case graduate medical education add-on amount.
- c) Within the CCR portion of the hybrid reimbursement system:
  - 1. The CCR ratio will be based on the peer group average CCR ratio.
  - 2. The per case capital add-on will be based on the peer group average per case capital add-on amount.
  - 3. The per case graduate medical education add-on (if applicable) will be based on the peer group average per case graduate medical education add-on amount.

1001.3 Outpatient Services

- a) Outpatient services by Georgia hospitals are reimbursed based on a determination of allowable

and reimbursable costs as determined from paid claims data.

- b) The determination of allowable and reimbursable costs is made retrospectively and is based on a cost report submitted by the hospital in accordance with Section 1002 and data included in the Nonallowable Costs Questionnaire. Only costs incurred in providing patient care are eligible for reimbursement. Generally, the Provider Reimbursement Manual (HCFA-15), "Principles of Reimbursement for Provider Costs" and the pertinent policies contained in this manual serve as the basis for classifying a cost as allowable.

Effective with dates of payment on and after July 1, 1997, the Department will reimburse for cost-based outpatient services at 90 percent of allowable operating costs plus 90 percent of allowable capital costs. The final determination of reimbursable costs will be made at the time outpatient settlements are made using audited cost reports.

- c) The amount of interim payment is calculated as a particular percentage of covered charges submitted to the Department. This percentage of charges is specific to each hospital and is based on the actual experience of the hospital during the last period for which the Department has performed a cost report review. The percentage of charges represents an estimate of a payment rate which approximates the amount of subsequently determined allowable cost. An interim reimbursement rate cannot exceed ninety percent of covered charges. Interim payments are subject to a cash settlement determination as described in Section 1003.
- d) All clinical diagnostic laboratory services performed for outpatients and nonpatients on and after October 1, 1984, are reimbursed at the lesser of the submitted charges or 60% of the prevailing Medicare charge level.
- e) Effective with dates of payment of February 1, 1991, and after, the maximum allowable payment